



Office of Health Facilities

Application for Nursing Home Facility

Reference Guide for New Applicants

Let's begin!

Log In to the platform

1 Enter your username and password.

2 Click the Log In button.

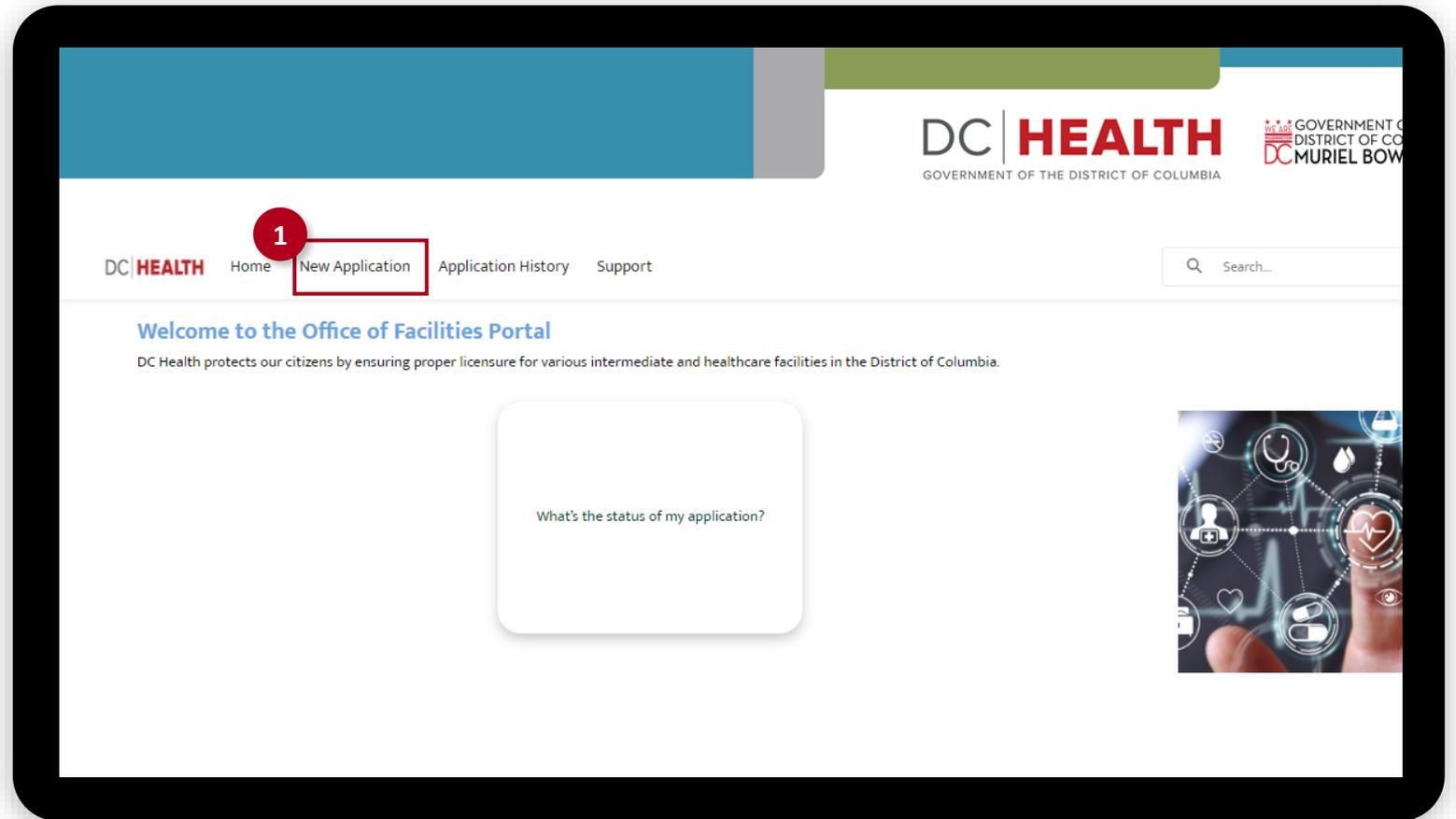


TIP: If you don't have an account click the **Create New Account** link.

The screenshot shows the DC Health login page. At the top right, it displays the DC Health logo and the Government of the District of Columbia logo with Mayor Muriel Bowser's name. The main content area features the DC Health logo, a welcome message, and a list of services. A red box highlights the login form, with callout 1 pointing to the username field (containing 'TestUser17') and callout 2 pointing to the password field (containing '.....') and the 'Log in' button. Below the form are links for 'Forgot your password?' and 'Forgot username?'. To the right of the form is a 'Create New Account' link. The page also includes a 'Welcome to the Office of Health Facilities Portal' section with a description of the HRLA and a list of services: 'Apply for a new medical facility license', 'Renew an existing medical facility license', 'Check the status of past applications', and 'Seek support related to interactions with this office'. An 'About DC Health' section follows, describing the organization's mission and responsibilities.

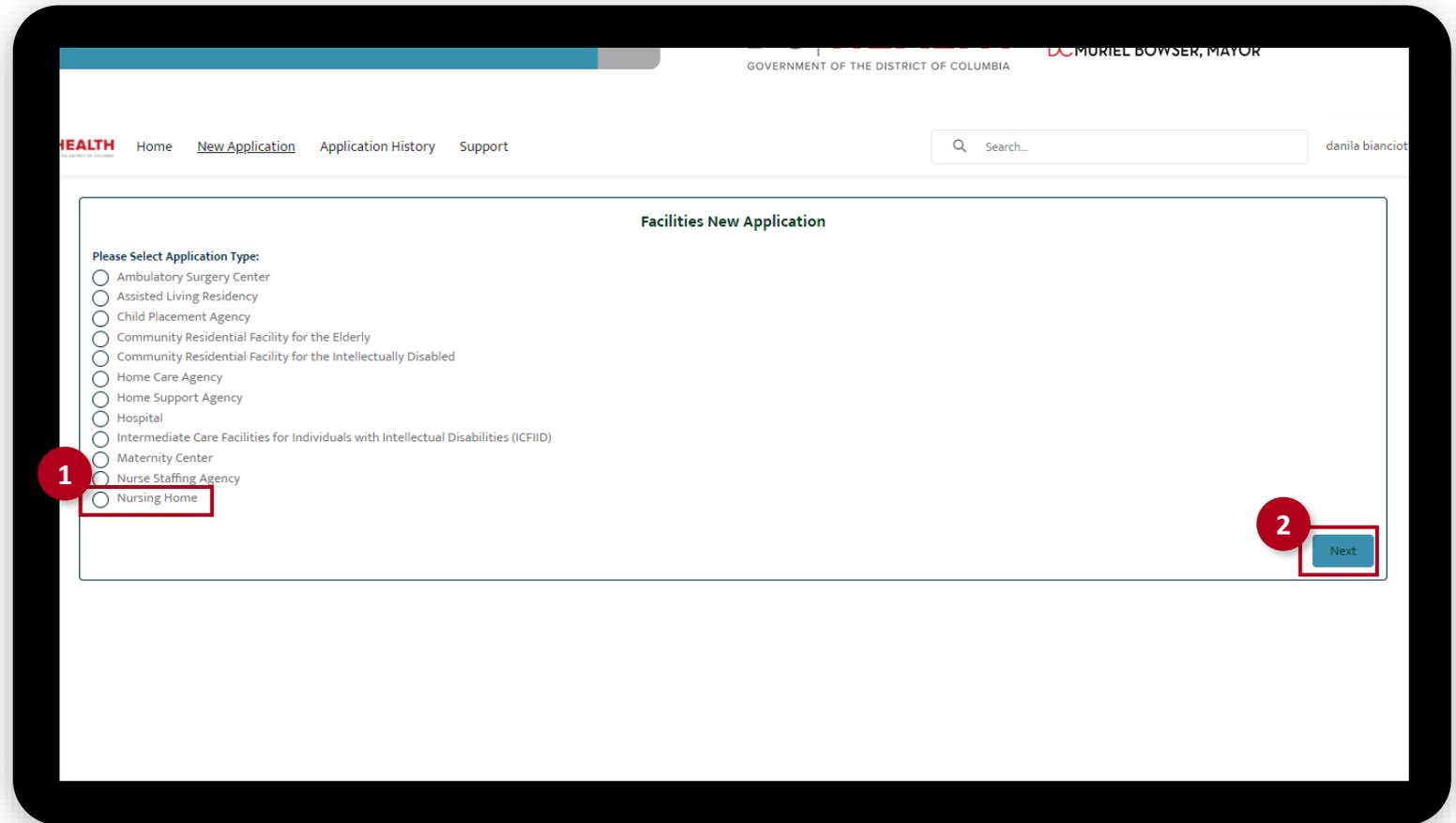
Navigate to the New Application screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



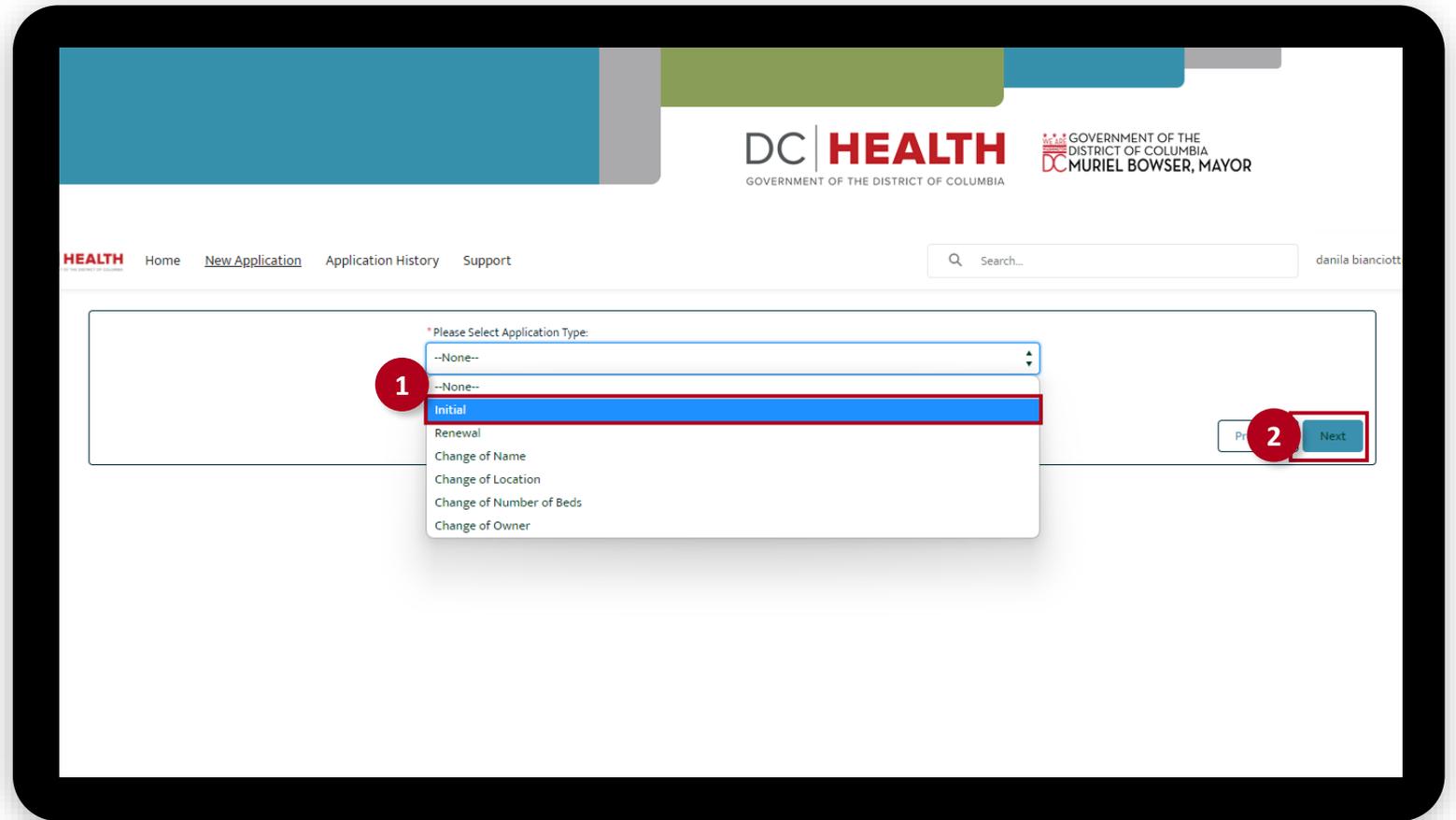
Select the Facilities New Application

- 1 Select the Nursing Home option from the list.
- 2 Click the Next button.



Select the Application Type

- 1 Select the **Initial** option from the drop-down list.
- 2 Click the **Next** button.



Fill out the Facility Identification Information

- 1 Fill out all the required fields.
- 2 Click the Save and Next button.

The screenshot shows a web form titled "Facility Identification" with a red border. A red circle with the number "1" is at the top left corner of the form area. A red circle with the number "2" is at the bottom right corner, over the "Save and Next" button. The form contains the following fields:

- *Facility Name: Cary Champlin
- *Street Address: 332 Littel Light
- *City: Cronaport
- *State: SC
- *Zip Code: 95695
- *Telephone Number: 586-202-7819
- *Fax Number: 010-629-2307
- *Email Address: your.email+fakedata93117@gmail.com
- *Facility Owned or Leased?: Owned
- *Types of Licensed Beds: Skilled Beds (Title 18 Only), Dual Beds (Title 18 and 19), Nursing Facility Beds (Title 19 only)
- *No. of Beds: 19
- *Nursing Facility Beds: 19

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Licensee Identification Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

EALTH Home [New Application](#) Application History Support

Quibusdam sed rerum eos occaecati voluptatibus quibus danila bianci

Licensee Identification

* Name
Camyle Luetngen

* Street Address
8492 Wolff Stravenue

* State
MN

* Telephone Number
051-381-7537

* Email Address
your.email+fakedata35151@gmail.com

* City
Dexterside

* Zip code
80559

* Fax Number
080-294-0399

* EIN #
436

Entity Type

* Select One
Public: State

Pr **2** Save and Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the principal/officers Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director)

1 Principal/Officer of the Licensee : 1

* First Name Wayne	Middle Name Major Keeling	* Last Name West
* Street Address 6235 McGlynn Pass	* City Wainomouth	
* State MS	* Zip code 07588	
* Telephone Number 117-632-9366	* Email your.email+fakedata95577@gmail.com	

* Has this person ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, of any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, or violence against a person or persons?
No

* Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license of the administrator or other officer of the facility? If yes, list applicable orders.
No

Add more Principals/Officers of the Licensee?

2 **Save and Next**

 **TIP:** If needed, select the **Add more Principals/Officers of the Licensee?**

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Person/Entity Information

- 1 Fill out all the required fields.
- 2 Click the Save and Next button.

1

Name of persons or entities (corporations, organizations, etc) having at least 10% interest in the licensee

Person/Entity having at least 10% interest in the Licensee: 1

* First Name	Middle Name	* Last Name
Lindsay	Hazel Paucek	Ondricka

* Street Address	* City
58 Ceasar Falls	Port Dina

* State	* Zip code
OK	210001

* Telephone Number	* Email
144-334-2995	your.email+fakedata71866@gmail.com

* Has this person ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, of any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, or violence against a person or persons?
No

* Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license of the administrator or other officer of the facility? If yes, list applicable orders.
No

Add more Persons/Entities having at least 10% interest in the Licensee?

2 Save and Next

 **TIP:** If needed, select the **Add more Persons/Entities having at least 10% interest in the Licensee?**

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Employee Information

1 Fill out all the required fields.

2 Click the **Save & Next** button.

Employee Information

* Name of Administrator
Emmitt Aufderhar

* District of Columbia Nursing Home Administrator License Number
425

* Has this person ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, of any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, or violence against a person or persons?
No

* Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license? Currently effective with regard to the administrator of the facility?
No

If yes, please attach documents.

Name of Facility Financial Officer
Joana Macejkovic

Name of Director of Nursing
Karson Bergstrom

Name of Medical Director
Elta Fritsch

Name of Social Service Director
Erika Brakus

Name of Activity Director
Savanah Pagac

DC Nurse License Number
416

DC Physician License Number
294

Upload Files Or drop files

2 Save & Text



TIP: If needed, use the **Upload Files** button to attach needed documentation.

The fields marked with * are mandatory and must be filled out to continue.

Select the Management Company Information

- 1 Select if the facility is managed by an entity other than the licensee. If Yes is selected, fill out the required information.
- 2 Click the Save & Next button.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the principal/officers of management company Information

- 1 If Yes was selected in the Management Company Information screen, fill out the required fields.
- 2 Click the Save and Next button.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

HEALTH Home [New Application](#) Application History Support

1 Name the principals/officers of the management company : (such as, CEO, President, VP, Secretary, Treasurer, Director)

Principal/Officer of the Management: 1

*First Name Middle Name *Last Name
Isabelle Green Huel Heller

*Street Address *City
1118 Turcotte Key South Caylahaven

*State *Zip code
WY 210001

*Telephone Number *Email
586-257-9095 your.email+fakedata53103@gmail.com

Add more Principals/Officers of the Management?

2 Save and Next

 **TIP:** This step is not needed if you selected No in the Management Company Information screen.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the persons/entity of management company Information

- 1 If Yes was selected in the Management Company Information screen, fill out the required fields.
- 2 Click the Save and Next button.

DC HEALTH DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HEALTH Home New Application Application History Support

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1 Name of persons or entity (corporations, organizations, etc) point of contact having at least 10% interest in the management company

Person/Entity having at least 10% interest in the Management: 1

* First Name Middle Name * Last Name
Stone Bertha Stamm Cummings

* Street Address * City
772 Ullrich Coves Rubyborough

* State * Zip code
UT 13331

* Telephone Number * Email
320-425-6425 your.email+fakedata36604@gmail.com

Add more Persons/Entities having at least 10% interest in the Management?

Pre **2** Save and Next



TIP: This step is not needed if you selected No in the Management Company Information screen.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

1 Fill out all the required fields.

2 Click the **Next** button.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

HEALTH Home [New Application](#) Application History Support

Officis nisi aut molestiae officia dolor voluptatem. danila bianci

Controlling Interests

Licensee:

* First Name Middle Name * Last Name

Leila Reichel Lambert Strosin Marisol Johns

* Email * Telephone Number

your.email+fakedata54573@gmail.com 402-898-3695

Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is for those owning 5% or more of the Licensee.

- 3 Fill out all the required fields.
- 4 Click the **Save & Next** button.

DC HEALTH DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR
GOVERNMENT OF THE DISTRICT OF COLUMBIA

HEALTH Home New Application Application History Support

Controlling Interests

Those owning 5% or more of the Licensee: 1

* First Name Middle Name * Last Name
Annabelle Christiansen Queen Wolff Kamron Torp

* Email * Telephone Number
your.email+fakedata30404@gmail.com 192-370-1418

Add more those owning 5% or more of the Licensee?

Pre Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is the Controlling Interests of each Officer of the licensee.

- 5 Fill out all the required fields.
- 6 Click the **Save & Next** button.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Home [New Application](#) Application History Support

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Controlling Interests

Each Officer of the licensee: 1

* First Name: Maia Middle Name: Erich Hackett * Last Name: Hintz

* Email: your.email+fakedata52002@gmail.com * Telephone Number: 542-449-8764

Add more Officers of the licensee?

Pre **6** Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is the Controlling Interests of each Board Member of the licensee.

- 7 Fill out all the required fields.
- 8 Click the **Save & Next** button.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Home [New Application](#) Application History Support

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Controlling Interests

Each Board Member of the licensee: 1

* First Name: Chauncey Middle Name: Hannah Rodriguez * Last Name: Murphy

* Email: your.email+fakedata14109@gmail.com * Telephone Number: 872-137-2888

Add more Board Members of the licensee?

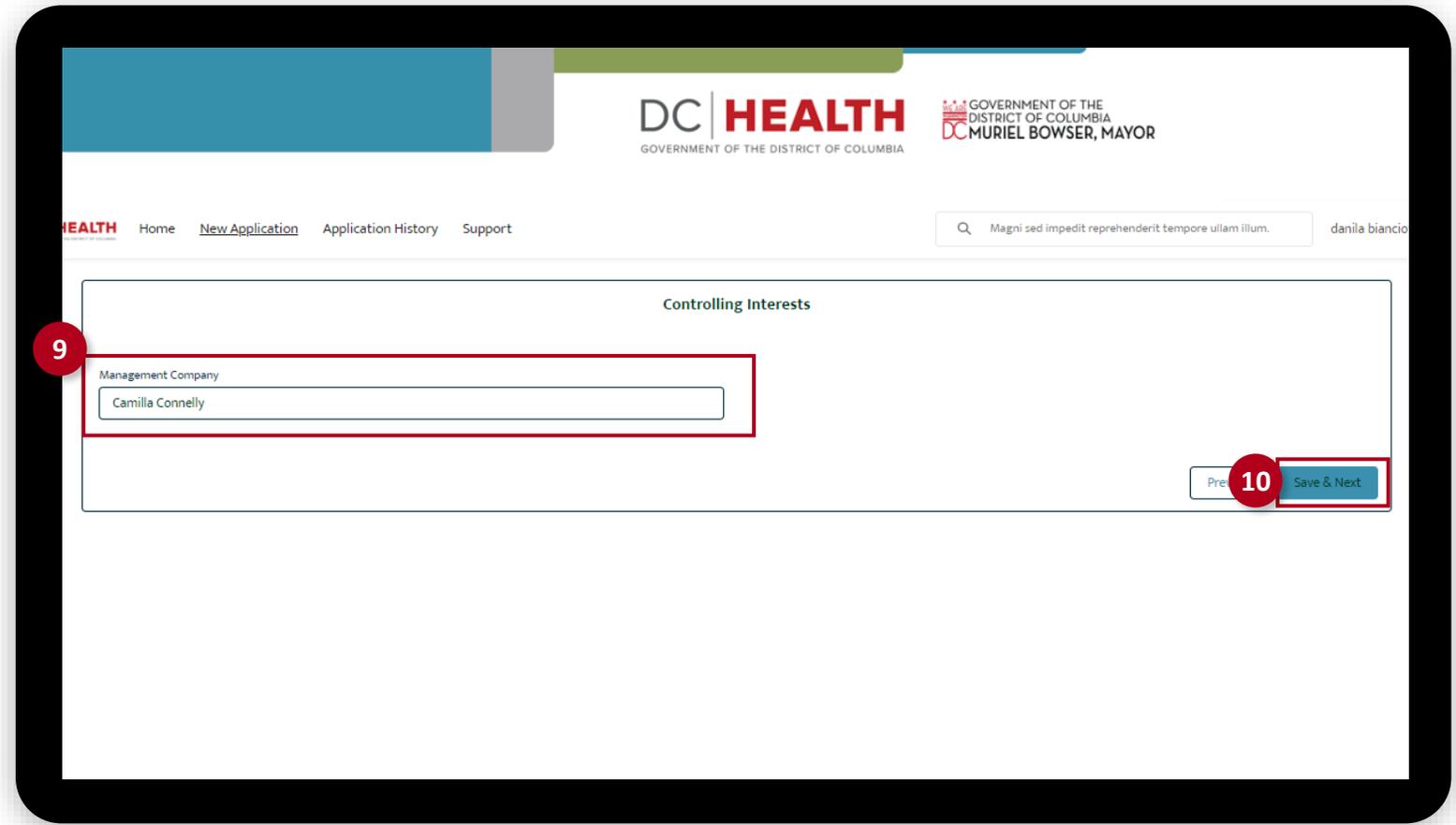
8 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is the name of the management company.

- 9 Fill out the name of the Management Company field.
- 10 Click the Save & Next button.



The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is the information of those owning 5% or more of the management company.

- 11 Fill out the required fields.
- 12 Click the Save & Next button.

DC HEALTH
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HEALTH Home [New Application](#) Application History Support

Search: Omnis a numquam vel sint cum. danila bianci

Controlling Interests

Those owning 5% or more of the management co: 1

* First Name: Ryan Goodwin Middle Name: Lambertborough * Last Name: Ziemann

* Email: your.email+fakedata38443@gmail.com * Telephone Number: 114-308-2762

Add more those owning 5% or more of the management co?

Previous **12** Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is the information of each Officer of the management company.

13 Fill out the required fields.

14 Click the Save & Next button.

DC HEALTH
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

HEALTH Home [New Application](#) Application History Support

Cum voluptas voluptates vel voluptate sunt repellat tem danila bianciot

Controlling Interests

Each Officer of the management company: 1

* First Name Savion Middle Name West Arleneworth * Last Name Tremblay

* Email your.email+fakedata67658@gmail.com * Telephone Number 523-595-4817

Add more Officers of the management company?

Pre 14 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Controlling Interests Information

This screen is the information of each Board Member of the management company.

- 15 Fill out the required fields.
- 16 Click the Save & Next button.

DC HEALTH | HOME | [New Application](#) | Application History | Support

DC HEALTH | GOVERNMENT OF THE DISTRICT OF COLUMBIA | MURIEL BOWSER, MAYOR

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Controlling Interests

Each Board Member of the management company: 1

* First Name: Celia | Middle Name: Cristmouth | * Last Name: Cummerata

* Email: your.email+fakedata36056@gmail.com | * Telephone Number: 899-314-9049

Add more Board Members of the management company?

Pre 16 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Organization Providing Goods, Leases, or Services Information

- 1 Fill out the required fields.
- 2 Click the **Next** button.

The screenshot shows a web form titled "Interest in Organizations Providing Goods, Leases, or Services to Facility" from the Government of the District of Columbia. The form is enclosed in a red border. A red circle with the number "1" is positioned at the top left of the form area. A red circle with the number "2" is positioned over the "Next" button at the bottom right of the form. The form contains several input fields: "First Name" (Elbert), "Middle Name" (Assunta Langosh), "Last Name" (Klocko), "Interest Organization" (3274 Velda Expressway), "Organization Street Address" (5392 Glover Turnpike), "City" (Darrickfort), "State" (IN), "Zip Code" (70544), and "Email" (your.email+fakedata60091@gmail.com). There is also a checkbox labeled "Add more Persons?". The page header includes "HEALTH" and navigation links: Home, New Application, Application History, Support. A search bar and a user name "danila bianciot" are also visible.

The fields marked with * are mandatory and must be filled out to continue.

Fill out Federal Certification Information

- 1 Fill out the required fields.
- 2 Click the Save & Next button.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

HEALTH Home [New Application](#) Application History Support

Ut nemo voluptate qui veritatis recusandae. danila bianciott

Federal Certification

* Does the facility participate in or intend to participate in the Medicaid program?
No

* Does the facility participate in or intend to participate in the Medicare program?
Yes

If applying for initial or change of licensed operator licensure, a separate application is required to participate in the Medicare and/or Medicaid programs.

* Has the applicant, licensee, or other controlling interest ever been excluded from Medicare or Medicaid?
No

Attach documentation regarding exclusion.

Proof of compliance with disclosure of ownership and controlling interest requirements of the Medicaid and Medicare programs shall be accepted in lieu of this submission.

If applying for change of licensed operator licensure and the NEW OWNER requests a NEW Medicare Provider Agreement, please attach.

Upload Files Or drop files

Prev **2** Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out Civil Verdict of Judgment and Outstanding Fines Information

- 1 Fill out the required fields and attach needed files clicking the Upload Files button.
- 2 Select Yes or No from the drop-down menu. If Yes is selected, fill out the required information.
- 3 Click the Save & Next button.

The screenshot shows a web form with two main sections. The first section, titled "Civil Verdict of Judgment", contains instructions for uploading files. It has two "Upload Files" buttons, each with a red circle containing the number "1" next to it. The second section, titled "Outstanding Fines", contains several fields. A red circle with the number "2" is next to the "Are there outstanding fines?" dropdown menu, which is currently set to "Yes". Below this, there are fields for "Fine Amount" (set to "500"), "Survey or application date the fine was imposed" (set to "Jul 5, 2022"), "Fines Assessed By" (set to "Agency for Health Care Regulation and Licensing"), and "Due date of fine" (set to "Aug 10, 2022"). At the bottom right, a red circle with the number "3" is next to the "Save & Next" button.

The fields marked with * are mandatory and must be filled out to continue.

Fill out additional information

- 1 Fill out the required fields and attach needed files clicking the Upload Files button.
- 2 Click the Save & Next button.

1

Upload Files Or drop files

Liability Insurance

Attach proof of current liability insurance coverage on malpractice and comprehensive general coverage in accordance with Title 22 DCMR 3205 Insurance coverage. In addition, attach a proof that the insurance carrier has a certificate of authority from the Department of Insurance to operate in the District of Columbia.

Upload Files Or drop files

Civil Verdict of Judgement

If applying for initial or change of licensed operator licensure, attach:

A. Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application, relating to medical negligence, violation of resident's rights, or wrongful death. A. Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application, relating to medical negligence, violation of resident's rights, or wrongful death.

Upload Files Or drop files

B. Copies of any civil verdict or judgment involving the applicant, related to such matters, within 30 days after filing with the clerk of the court.

Upload Files Or drop files

Risk Management and Quality Assurance

If applying for initial or change of licensed operator licensure, submit the facility plan for quality assurance and for conducting risk management.

Upload Files Or drop files

2 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out Insurance Coverage information

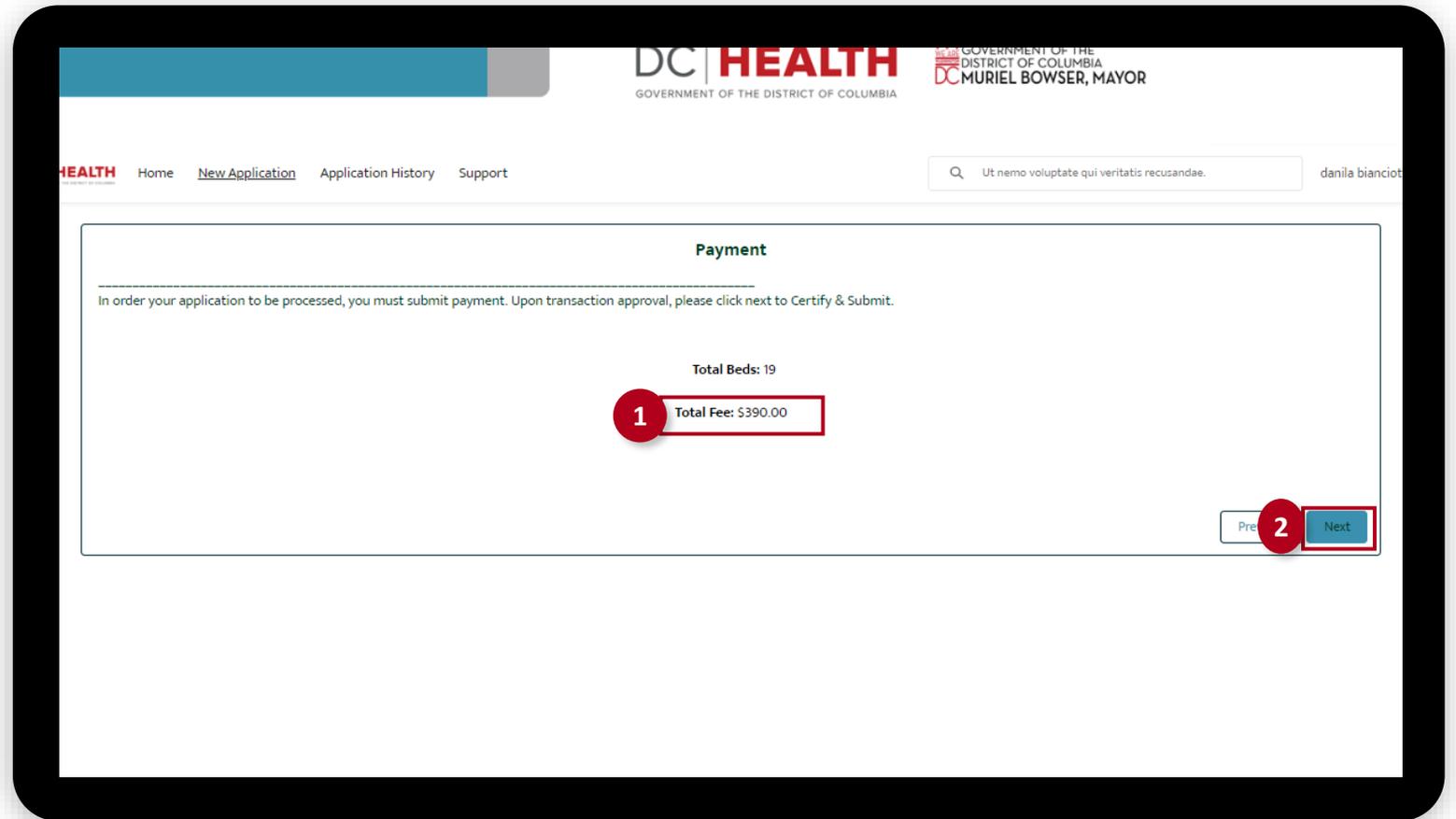
- 1 Select **Yes/No** in the required fields. Upload documentation by clicking the **Upload Files** button.
- 2 Click the **Next** button.

The screenshot shows a web application interface for DC HEALTH. At the top right, there is a logo for DC HEALTH and the Government of the District of Columbia, along with the name MURIEL BOWSER, MAYOR. Below the logo is a navigation menu with links for Home, New Application, Application History, and Support. A search bar contains the text "Labore aspernatur minima fugiat et." and a user name "Dani Bian" is displayed. The main content area is titled "InsuranceCoverage" and contains two mandatory questions, each with a dropdown menu showing "--None--". The first question is "* Does the facility have Liability insurance?" and the second is "* Does the facility have Worker's Compensation insurance?". A red box highlights these two questions and the "Next" button at the bottom right of the form. A red circle with the number "1" is placed over the first question, and a red circle with the number "2" is placed over the "Next" button.

The fields marked with * are mandatory and must be filled out to continue.

Payment

- 1 Check if **Total Fee** is correct.
- 2 Click the **Next** button.



The fields marked with * are mandatory and must be filled out to continue.

Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

DC HEALTH Home [New Application](#) Application History Support

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Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

Billing Address	Payment Info
7429 Shanahan Via	Elza Abbott
953 Hadley Lakes	3714 496353 98431
North Jaylon	11 / 25
New Mexico ?
32284	

Pay \$390.00

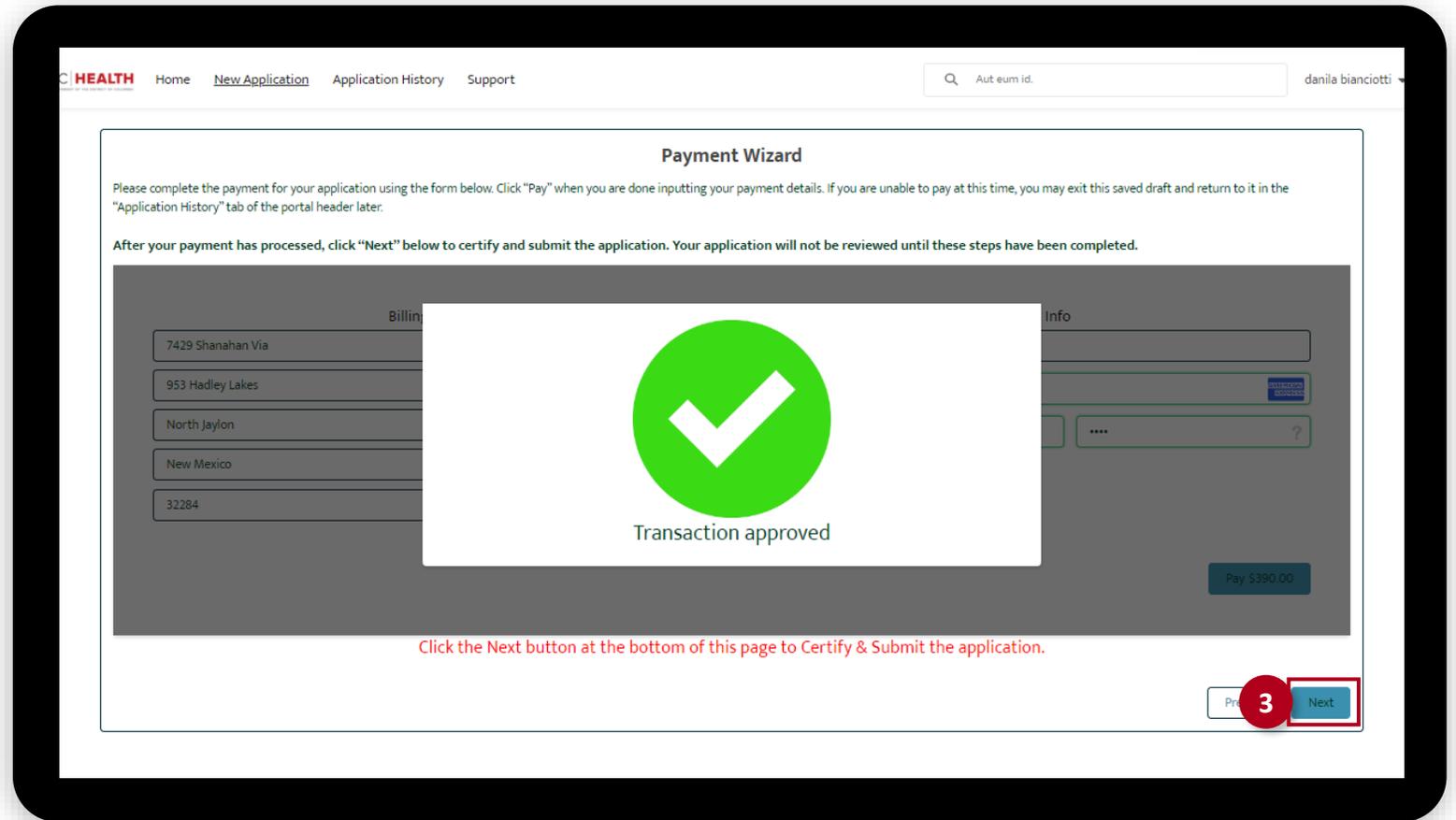
Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

Payment Wizard



- 3 Once the Transaction is approved, click the **Next** button.



Certify and Submit

1 Fill out the **Name** and **Date** fields.

2 Click the **Submit** button.

Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties*. This information will be held confidential by the Department of Health.

*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect; (b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

* Name
Makenna

* Date
Oct 11, 2022

Submit

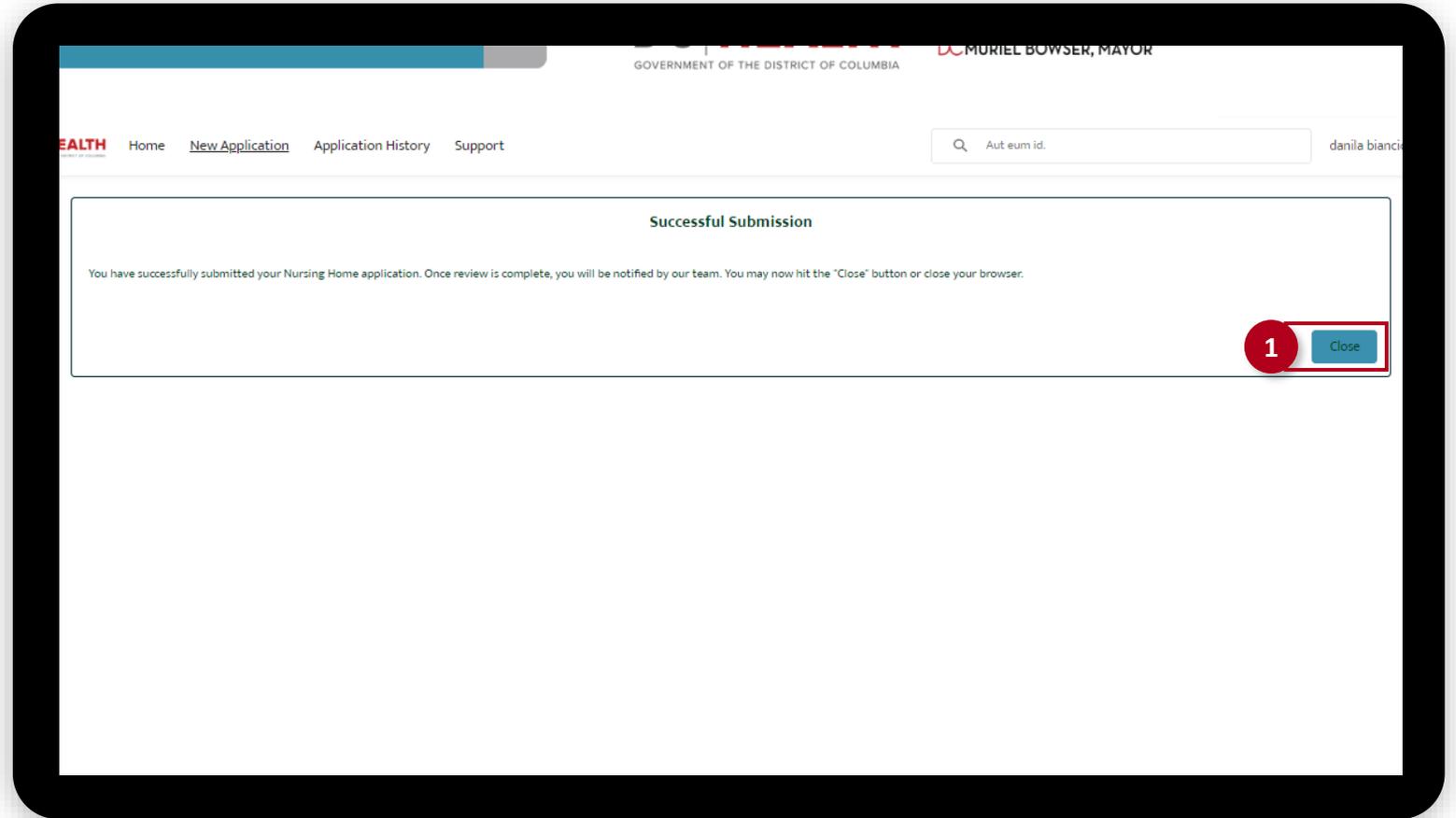


TIP: The date should correspond to today's date.

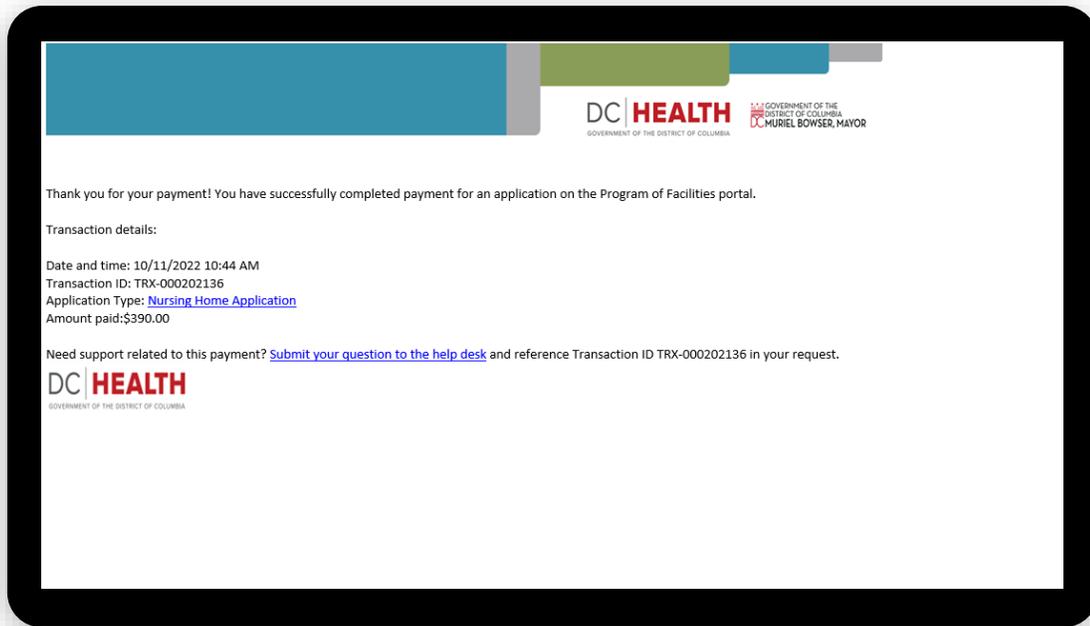
*The fields marked with * are mandatory and must be filled out to continue.*

Close the Application

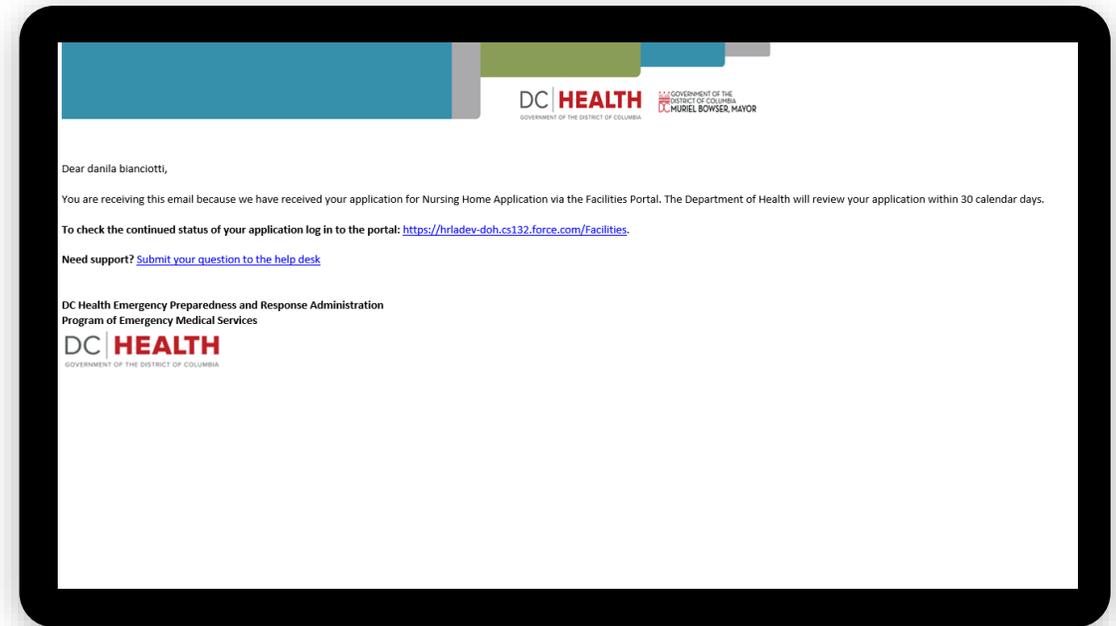
- 1 You have finished submitting your application. Click the **Close** button.



E-mail Confirmation



1 Check if you have received confirmation of payment.



2 Check if you have received confirmation for your application.

Thank you!